

Smile Studio Associates Dentistry



Patient Information

Patients Name: _____ D.O.B. ___/___/___
Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Phone: H-f () _____ W-f () _____ C-() _____
Email: _____ Marital Status: _____
Employer: _____ Work Address: _____
Occupation: _____
S.S. #: _____ - _____ - _____ D.L#: _____ State: _____
Referred by: _____
How did you know about us? _____

Responsible Party in Case of Emergency:

Name: _____ Address: _____
Phone: H- () _____ W- () _____ C- () _____
Relationship to patient: _____

Insurance Information

Insurance Co.: _____
Phone: () _____ Group#: _____
Primary Insured: _____ S.S. #: _____ - _____ - _____
Employer: _____ D.O.B. ___/___/___

Release:

- *I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
*I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.
*I authorize the release of any information concerning my health care, advice to another dentist.
*I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
*I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill of service. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid in whole or in part by my dental care payer.
*I attest to the accuracy of the information on this page.

Patients/Guardians Signature: _____ Date: _____

HEALTH HISTORY

English

Patient Name: _____

Patient Identification Number: _____

Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

- | | | | | | |
|----|-----|----|---|--|--|
| 1. | Yes | No | Is your general health good? | | |
| 2. | Yes | No | Has there been a change in your health within the last year? | | |
| 3. | Yes | No | Have you been hospitalized or had a serious illness in the last three years?
If YES, why? | | |
| 4. | Yes | No | Are you being treated by a physician now? What for? _____
Date of last medical exam: _____ Date of last Dental exam: _____ | | |
| 5. | Yes | No | Have you had problems with prior dental treatment? | | |
| 6. | Yes | No | Are you in pain now? | | |

II. HAVE YOU EXPERIENCED:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|------------------------|
| 7. | Yes | No | Chest pain (angina)? | 18. | Yes | No | Dizziness? |
| 8. | Yes | No | Swollen ankles? | 19. | Yes | No | Ringing in ears? |
| 9. | Yes | No | Shortness of breath? | 20. | Yes | No | Headaches? |
| 10. | Yes | No | Recent weight loss, fever, night sweats? | 21. | Yes | No | Fainting spells? |
| 11. | Yes | No | Persistent cough, coughing up blood? | 22. | Yes | No | Blurred vision? |
| 12. | Yes | No | Bleeding problems, bruising easily? | 23. | Yes | No | Seizures? |
| 13. | Yes | No | Sinus problems? | 24. | Yes | No | Excessive thirst? |
| 14. | Yes | No | Difficulty swallowing? | 25. | Yes | No | Frequent urination? |
| 15. | Yes | No | Diarrhea, constipation, blood in stools? | 26. | Yes | No | Dry mouth? |
| 16. | Yes | No | Frequent vomiting, nausea? | 27. | Yes | No | Jaundice? |
| 17. | Yes | No | Difficulty urinating, blood in urine? | 28. | Yes | No | Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | | | | | | | |
|-----|-----|----|---|-----|-----|----|---------------------------|
| 29. | Yes | No | Heart disease? | 40. | Yes | No | AIDS. |
| 30. | Yes | No | Heart attack, heart defects? | 41. | Yes | No | Tumors, cancer? |
| 31. | Yes | No | Heart murmurs? | 42. | Yes | No | Arthritis, rheumatism? |
| 32. | Yes | No | Rheumatic fever? | 43. | Yes | No | Eye diseases? |
| 33. | Yes | No | Stroke, hardening of arteries? | 44. | Yes | No | Skin diseases? |
| 34. | Yes | No | High blood pressure? | 45. | Yes | No | Anemia? |
| 35. | Yes | No | Asthma, TB, emphysema, other lung diseases? | 46. | Yes | No | Syphilis or Gonorrhea |
| 36. | Yes | No | Hepatitis, other liver disease? | 47. | Yes | No | Herpes? |
| 37. | Yes | No | Stomach problems, ulcers? | 48. | Yes | No | Kidney, bladder disease? |
| 38. | Yes | No | Allergies to: drugs, foods, medications, latex? | 49. | Yes | No | Thyroid, adrenal disease? |
| 39. | Yes | No | Family history of diabetes, heart problems, tumors? | 50. | Yes | No | Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | | | | | | | |
|-----|-----|----|-------------------------|-----|-----|----|---------------------|
| 51. | Yes | No | Psychiatric care? | 56. | Yes | No | Hospitalization? |
| 52. | Yes | No | Radiation treatments? | 57. | Yes | No | Blood transfusions? |
| 53. | Yes | No | Chemotherapy? | 58. | Yes | No | Surgeries? |
| 54. | Yes | No | Prosthetic heart valve? | 59. | Yes | No | Pacemaker? |
| 55. | Yes | No | Artificial joint? | 60. | Yes | No | Contact lenses? |

V. ARE YOU TAKING:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|----------------------|
| 61. | Yes | No | Recreational drugs? | 63. | Yes | No | Tobacco in any form? |
| 62. | Yes | No | Drugs, medications, over-the-counter medicines
(including Aspirin), natural remedies? | 64. | Yes | No | Alcohol? |

Please list: _____

VI. WOMEN ONLY:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|-----------------------------|
| 65. | Yes | No | Are you or could you be pregnant or nursing? | 66. | Yes | No | Taking birth control pills? |
|-----|-----|----|--|-----|-----|----|-----------------------------|

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain:

To the best of my knowledge, I have answered even¹ question completely and accurately. I will inform my dentist of any change in my health and/or medication

Patient's signature: _____

Date: _____

RECALL REVIEW:

Patient's signature: _____

Date: _____

Smile Studio Associates Dentistry



Consent Form

I authorize Smile Studio Associates of SM to use all medicaments and therapeutic procedures necessary to complete my dental treatment as required. I understand that dental treatment may consist of the usage of local anesthesia? Performance of Root Canal Treatment, Cerec, Implant Surgery, Periodontal Surgery, Extractions and Veneers.

I also certify that my treatment plan, along with benefits and risks have been completely explained to me, and all of my questions have been adequately answered.

Payments must be made at the time the service is rendered. I understand estimates are approximate and may change if there are any unforeseen complications during treatment.

I also understand that Smile Studio Associates of SM is continuously involved in Continuing Education Courses. Therefore, my treatment can be used as a case, presentation during Smile Studio Associates of SM lectures.

I also allow the use of my dental treatment for marketing purposes in the form of before and after smiles photographs, without the publication of any personal information, unless my prior approval of testimonials.

Smile Studio Associates of SM is committed to providing our patient with the highest quality of dental services. However, the success of all treatment also depends on the patient's compliance with post-operative instructions and the-adherence to oral hygiene appointments every three or six months.

Patient's signature: _____ Date: _____

Doctor's signature: _____ Date: _____

Smile Studio Associates Dentistry



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone (____) _____ Email: _____

Social security #: _____

Purpose of consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Name: Lilitana Diaz

Telephone: (305) 856- 1488 Fax: (305) 856- 8586

Email: _____

Address: 1760 Coral Way, Coral Gables, Fl, 33145

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: _____ Date: _____

FINANCIAL POLICY

In order to avoid any confusion about the payment policies of this office or the utilization of your dental insurance, we have assembled the following outline to help answer any questions that may arise. If you have any other questions please feel free to ask us any time.

PAYMENT POLICY: In an effort to make needed services more affordable, we have initiated a policy to encourage payment when services are rendered. This plan helps to reduce your cost and our overhead without diminishing the quality of our services.

*We DO accept credit cards

Visa

MasterCard Discover

Discover

*Other _____

*We DO NOT have an open account system of payment.

*Payment is due when services are rendered.

*I authorize SSD to charge my card for services shall my insurance portion of the payment is not collected 60 days from the service date

 Print your name

INSURANCE POLICY: We are happy to accept your dental insurance and with you and your insurance company.

*Please bring a copy of your insurance booklet so we may keep it on file in our office.

*We will compute an estimate of your percentage of payments at each visit; this payment is due at the time services are rendered.

*If an insurance account shows an overdue balance, the patient should assume that the insurance company has paid its share and the present balance due is the responsibility of the patient. After the balance is paid. If you feel your insurance has made a mistakes, we will gladly provide the information necessary so your can be reimbursed by your insurance company.

*Any question concerning the reasoning behind insurance payments should be addressed to either your employer or insurance company.

*Please remember that any responsibility due rests with the patient.

Please let us know if we can be of any assistance, we will be glad to help you.

Name _____ Date _____

Signature _____

Smile Studio Associates Dentistry



Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claims. If you have any questions please ask us. Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within the 90 days, I will be responsible for the full amount owed to Smile Studio Associates of SM.

I understand and agree that I am responsible for the estimated amount not paid by the insurance company.

I understand that after the insurance company pays to Smile Studio & Assoc. there could still be a balance remaining, for which I am responsible.

I understand and agree that I am responsible for any portion of my balance not covered by insurance.

I understand and agree that if the estimate by the insurance company indicates a large amount due by me and I feel I cannot pay it during treatment, I can request a written financial agreement (terms to be discussed at that time).

I understand that any balance remaining after insurance and termination of treatment must be paid by me to Smile Studio Associates of SM. within the 90 days of the termination of treatment. If I fail to do so other methods of collection may be used including legal means to collect the debt if any, and all expenses incurred for this purpose will be added to my account.

Signature of responsible party

Office manager

Date

Smile Studio Associates Dentistry



INSURANCE COLLECTION POLICY

Please be advised that our accounting department requires you to sign this statement in order to process your insurance information.

0-30 We will submit your insurance within 30 days from your date of service.

30-60 We expect payment from your insurance company within 30-60 days.

60-90 If payment has not been received within 60-90 days, you will be noticed by our office that your bill has not been paid and it is your responsibility to pay it. It is also your responsibility to speak directly to your insurance company for any possible reimbursement.

90-120 If within 90-120 days there has been no payment on your account, it will be turned over to the collections department and this matter will be taken very seriously.

I have read, understood, and agree with the above statements. I understand that ultimately my account is my responsibility.

Patient signature

Date